

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5694

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

~~tem 9 Film C288 6/12/67~~

45682

1. PLACE OF DEATH a. COUNTY		Howard		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)		a. STATE		Maryland		b. COUNTY		Howard			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				Road - Fels Lane				Ellicott City				189 Main Street					
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month		Day		Year			
RANDOLPH		EUGENE		BRIGHTWELL				May		29,		1961					
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.					
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12/22/27/		32 33 yrs.		Months		Days		Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?					
Ho. Co. Police Dept.				Patrolman				Maryland									
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME											
Dalmas Davis						Mary C. Brightwell											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT				Address					
Yes 1946--1948				212-24-2917				Mary C. Brightwell				189 Main St. Ellicott City					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wounds of chest and head																	
981X DUE TO																	
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
				Shot in head and chest													
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
Approx. 1:45 PM 5/29/ 19 61				While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>				Road				Ellicott City, Howard, Md.					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>																	
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>																	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>																	
DATE SIGNED 5/29/61																	
ACTUAL SIGNATURE Russell S. Fisher, M.D.																	
EXAMINER'S NAME (Type)																	
Address (Street, city, town, or county)																	
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF				22c. NAME OF CEMETERY OR CREMATORY				22d. LOCATION (City, town, or country) (State)					
Burial				6/2/61				Poplar Springs Meth.				Poplar Springs, Maryland					
23. FUNERAL DIRECTOR																	
F. C. Higginbotham																	
ADDRESS																	
Ellicott City, Md.																	
24a. REC'D BY REGISTRAR																	
DATE JUN 5 '61																	
24b. REGISTRAR'S SIGNATURE																	
Arthur S. Huns																	

VS. A15ME
5M 9/60



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Section 1: [Illegible text]

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CERTIFICATE OF DEATH

2002



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5696

CERTIFICATE OF DEATH

Reg. Dist. No.

05685

1. PLACE OF DEATH a. COUNTY HOWARD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HOWARD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WOODSTOCK		c. LENGTH OF STAY IN 1b 13 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WOODSTOCK COLLEGE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) REV. JOHN First Middle Last HARDING FISHER S.J.		4. DATE OF DEATH MAY Month Day Year 4, 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 9, 1875
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ROMAN CATHOLIC PRIEST, JESUIT ORDER		10b. KIND OF BUSINESS OR INDUSTRY BROOKLYN, N. Y.	
11. BIRTHPLACE (State or foreign country) BROOKLYN, N. Y.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT REV. JOHN L. BRUNETT		Address B. J. WOODSTOCK, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Previous Coronary thrombosis DUE TO (c) 44.5 years		INTERVAL BETWEEN ONSET AND DEATH 44.5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1951 , to May 4 , 19 61 , that I last saw the deceased alive on May 2 , 19 61 , and that death occurred at 7:20 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) BALTO. 2, MD. DATE SIGNED 5/5/61			
ACTUAL SIGNATURE Harold H. Burns M.D.		PHYSICIAN'S NAME (Type) Harold H. Burns, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5/6/61	
22c. NAME OF CEMETERY OR CREMATORY WOODSTOCK COLLEGE		22d. LOCATION (City, town, or county) (State) WOODSTOCK MD.	
23. FUNERAL DIRECTOR'S SIGNATURE H. W. MEARS & SON		ADDRESS 805 N. CALVERT ST.	
24a. REC'D BY REGISTRAR MAY 8 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5697

05686

1. PLACE OF DEATH a. COUNTY Howard b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Ellicott City c. LENGTH OF STAY IN 1b Gas Station - Junction Rt. 40 & 29 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore (29) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 316 Athol Avenue d. STREET ADDRESS 316 Athol Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CHARLES F. GALLION JR.				4. DATE OF DEATH Month Day Year May 29, 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOV. 1, 1929	
9. AGE (In years last birthday) 31 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SERVICE STATION ATT.		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES F. GALLION SR.				14. MOTHER'S MAIDEN NAME RUBY MCCLURE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 216-24-2948		16. SOCIAL SECURITY NO. 216-24-2948		17. INFORMANT MRS PATRICIA L. GALLION, 316 ATHOL AVE			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wounds of chest and head with bilateral hemothorax Conditions, if any, which gave rise to immediate cause (b) 981X (a), stating the underlying cause last. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Shot in head and chest					
20c. TIME OF INJURY Approx. 1:45 PM		Month, Day, Year 5/29/1961		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Gas Station	
20f. (City or town) Rural-Ellicott City, Howard,		20g. (County) (State) Md.					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Russell S. Fisher, M.D.				DATE SIGNED 5/29/61			
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5/1/61		22c. NAME OF CEMETERY OR CREMATORIAL LOU DON PK.		22d. LOCATION (City, town, or county) (State) BALTO. MD.	
23. FUNERAL DIRECTOR WITZKE FUN. DIR. 4101 EDMONDSON AVE				24a. REC'D BY REGISTRAR MAY 31 '61			
24b. REGISTRAR'S SIGNATURE Arthur S. Kenna							

TO DEPARTMENT OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 Medical Examiner's Certificate should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
10-10-1961

(M)

Final - Willard City

Final - Willard City (24)

See Station - Willard City in 20

MAILING

10-10-1961

U.S.A.

M.D.

1-19-1961

CHARLES E. GALLIN 28

21-2-1961 Mrs. Patricia J. Gallin, 316 1/2

1-19-1961

1-19-1961

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TO HOSPITAL: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

after death. Page 4

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

5698

05687

1. PLACE OF DEATH a. COUNTY Howard County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City c. LENGTH OF STAY IN 1b Ellicott City d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route #29		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard County c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City d. STREET ADDRESS Route #29 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Annie Middle E. Last Jubb		4. DATE OF DEATH Month May Day 29 Year 1961				
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 26, 1872	9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR Months 88	IF UNDER 24 HRS. Hours 88 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Maryland		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Franklin C. Hall		14. MOTHER'S MAIDEN NAME Margaret Campbell				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-05-2370		17. INFORMANT Address Mrs. Lawrence C. Mosner, R. #29, Ellicott City		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peripheral Vascular Collapse 782.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 10 min.						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 19, 1960 to May 29, 1961 , that (I) (we) last saw the deceased alive on May 29, 1961 , and that death occurred at 9:15 M., from the causes and on the date stated above.						
22a. SIGNATURE Thomas F. Herbert		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5-29-61		
22c. PHYSICIAN'S NAME (Type) Thomas F. Herbert, M.D.		22d. ADDRESS Ellicott City, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6-1-61		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION (City, town, or county) (State) 3310 Taylor Avenue
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street				25a. REC'D BY REGISTRAR DATE JUN 1 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kline

MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
CERTIFICATE OF DEATH

1888

Howard County
Hillside City
House 739
Anne
Female - white
Married
Husband
Franklin D. Hill
Margaret Campbell
Age 88
Dec. 20, 1875
May 29 - 01

(M)

(1)

217-02-2370 Mr. Lawrence D. Haines, R. 739, Hillside City

Copy of Certificate

James E. Hill
Thomas F. Hill
370 Taylor Avenue
B-1-01
Bureau of Vital Records

1
FOR STATE
HEALTH DEPT.

M

I

VS. A15ME
5M 9/60

TO DECEASED MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

5699

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05688

1. PLACE OF DEATH a. COUNTY Howard b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Laurel c. LENGTH OF STAY IN b 9 Mos d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Maple Hill Apts., All Saints Road				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Laurel d. STREET ADDRESS Maple Hill Apts., All Saints Road e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
3. NAME OF DECEASED (Type or print) First BETTY Middle JEDETTA Last KOZSIS				4. DATE OF DEATH Month May Day 22 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 20 May - 1960	
9. AGE (In years last birthday) 1 yrs.		IF UNDER 1 YEAR Months 1 Days 22 Hours 19 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James P. Kozsis				14. MOTHER'S MAIDEN NAME Ellie Nagel			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Maple Hill Apts., All Saints Rd, Laurel, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hydrocephalus DUE TO 344 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE W. Bradley King, Jr., M.D.				DATE SIGNED 5/23/61			
EXAMINER'S NAME (Type) W. Bradley King, Jr., M.D.				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 5/24/61		22c. NAME OF CEMETERY OR CREMATORY Baltimore National	
22d. LOCATION (City, town, or country) (State) Baltimore - Md				23. FUNERAL DIRECTOR Earl S. Woberton Funeral Home Inc			
ADDRESS 6306 - Belair Rd, Baltimore 4, Md				24a. REC'D BY REGISTRAR DATE MAY 25 '61		24b. REGISTRAR'S SIGNATURE Clarence S. Harris	

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DEPARTMENT OF HEALTH

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CERTIFICATE OF DEATH

Reg. Dist. No.

05689

5700

1. PLACE OF DEATH a. COUNTY MARYLAND Howard				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY —			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shaffers Convalescent Retreat				d. STREET ADDRESS 2728 Jefferson St.			
3. NAME OF DECEASED (Type or print) First MARIE Middle O. Last MARSHALL				4. DATE OF DEATH Month May Day 1 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-28-1884	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Owings Mills, Md	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Chas.E. Angel, 818 Augusta Ave. Balto. 29, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic Cardiovascular Disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 10 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-29 , 19 60 , to 5-1 , 19 61 , that I last saw the deceased alive on 4-30 , 19 61 , and that death occurred at 5:55 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Thomas F. Herbert M.D.				ADDRESS (Street, city or town, state) Ellicott City, Md		DATE SIGNED 5-1-61	
PHYSICIAN'S NAME (Type) Thomas F. Herbert, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-3-61		22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel		22d. LOCATION (City, town, or county) (State) Littlestown, Md Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR DATE MAY 3 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HARRIS		SEX Male		AGE 68	
DATE OF DEATH 10-15-1968		TIME OF DEATH 10:00 AM		PLACE OF DEATH Home	
NAME OF PHYSICIAN Dr. J. H. Harris		NAME OF HOSPITAL None		NAME OF NURSING HOME None	
CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural		PLACE OF INTERMENT None	
DATE OF BIRTH 10-15-1900		PLACE OF BIRTH Baltimore, Md.		OCCUPATION None	
MARITAL STATUS Married		EDUCATION High School		RELIGION None	
PREVIOUS ILLNESS None		PREVIOUS SURGERY None		PREVIOUS TRAUMA None	
PREVIOUS DRUGS None		PREVIOUS ALCOHOL None		PREVIOUS TOBACCO None	
PREVIOUS RHEUMATISM None		PREVIOUS GOUT None		PREVIOUS DIABETES None	
PREVIOUS HYPERTENSION None		PREVIOUS ASTHMA None		PREVIOUS EPILEPSY None	
PREVIOUS PSYCHIC ILLNESS None		PREVIOUS MENTAL ILLNESS None		PREVIOUS PHYSICAL ILLNESS None	
PREVIOUS INJURY None		PREVIOUS POISONING None		PREVIOUS OTHER None	
PREVIOUS DEATH None		PREVIOUS BURIAL None		PREVIOUS CREMATION None	
PREVIOUS TRANSPLANT None		PREVIOUS ORGAN DONOR None		PREVIOUS ORGAN RECIPIENT None	
PREVIOUS SURGICAL None		PREVIOUS MEDICAL None		PREVIOUS DENTAL None	
PREVIOUS OPTICAL None		PREVIOUS AURAL None		PREVIOUS NASAL None	
PREVIOUS THROAT None		PREVIOUS LARYNGEAL None		PREVIOUS TRACHEAL None	
PREVIOUS BRONCHIAL None		PREVIOUS PULMONARY None		PREVIOUS PERICARDIAL None	
PREVIOUS VENTRICULAR None		PREVIOUS ATRIAL None		PREVIOUS CORONARY None	
PREVIOUS CIRCULATORY None		PREVIOUS RESPIRATORY None		PREVIOUS DIGESTIVE None	
PREVIOUS GENITOURINARY None		PREVIOUS SKIN None		PREVIOUS BLOOD None	
PREVIOUS IMMUNE None		PREVIOUS ENDOCRINE None		PREVIOUS NERVOUS None	
PREVIOUS MUSCULAR None		PREVIOUS SKELETAL None		PREVIOUS OTHER None	
PREVIOUS DEATH None		PREVIOUS BURIAL None		PREVIOUS CREMATION None	
PREVIOUS TRANSPLANT None		PREVIOUS ORGAN DONOR None		PREVIOUS ORGAN RECIPIENT None	
PREVIOUS SURGICAL None		PREVIOUS MEDICAL None		PREVIOUS DENTAL None	
PREVIOUS OPTICAL None		PREVIOUS AURAL None		PREVIOUS NASAL None	
PREVIOUS THROAT None		PREVIOUS LARYNGEAL None		PREVIOUS TRACHEAL None	
PREVIOUS BRONCHIAL None		PREVIOUS PULMONARY None		PREVIOUS PERICARDIAL None	
PREVIOUS VENTRICULAR None		PREVIOUS ATRIAL None		PREVIOUS CORONARY None	
PREVIOUS CIRCULATORY None		PREVIOUS RESPIRATORY None		PREVIOUS DIGESTIVE None	
PREVIOUS GENITOURINARY None		PREVIOUS SKIN None		PREVIOUS BLOOD None	
PREVIOUS IMMUNE None		PREVIOUS ENDOCRINE None		PREVIOUS NERVOUS None	
PREVIOUS MUSCULAR None		PREVIOUS SKELETAL None		PREVIOUS OTHER None	

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THE DEPARTMENT OF HEALTH, BALTIMORE, MD. HAS RECEIVED THE FOLLOWING INFORMATION FROM THE PHYSICIAN, HOSPITAL, NURSING HOME, OR OTHER SOURCE, THAT THE ABOVE NAMED PERSON DIED ON THE DATE AND AT THE PLACE INDICATED. THE CAUSE OF DEATH IS AS STATED. THE MANNER OF DEATH IS AS STATED. THE PLACE OF INTERMENT IS AS STATED. THE DEPARTMENT OF HEALTH, BALTIMORE, MD. HAS RECEIVED THE FOLLOWING INFORMATION FROM THE PHYSICIAN, HOSPITAL, NURSING HOME, OR OTHER SOURCE, THAT THE ABOVE NAMED PERSON DIED ON THE DATE AND AT THE PLACE INDICATED. THE CAUSE OF DEATH IS AS STATED. THE MANNER OF DEATH IS AS STATED. THE PLACE OF INTERMENT IS AS STATED.

1
FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
5701 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05690

1. PLACE OF DEATH a. COUNTY Howard			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Poplar Springs, Mt. Airy Rt. 3 d. STREET ADDRESS Hardy Road		
3. NAME OF DECEASED (Type or print) RUTH ELOISE MULLINIX			4. DATE OF DEATH Month May Day 5 Year 1961		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 14, 1924		9. AGE (In years last birthday) 36 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Long Corner, Md	
13. FATHER'S NAME Millard Fillmore Mullinix			14. MOTHER'S MAIDEN NAME Ethel Day Buxton		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-40-8794		17. INFORMANT Mrs Harry Dove, Mt. Airy, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Barbiturate intoxication (rapid-acting) 970.2 DUE TO Conditions, if any, which gave rise to immediate cause (b) Overingestion of barbiturates (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Overingestion of barbiturates			
20c. TIME OF INJURY Month, Day, Year 5/4 1961 Hour a.m. 7 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> el work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Porch of church		20f. (City or town) Howard	(County) (State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE W. Bradley King, Jr., M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 5/6/61	
EXAMINER'S NAME (Type) W. Bradley King, Jr., M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 8, 1961	22c. NAME OF CEMETERY OR CREMATORY Howard Chapel Meth.		22d. LOCATION (City, town, or country) (State) Long Corner, Md.	
23. FUNERAL DIRECTOR Olin L. Mobaworth		ADDRESS Damascus, Md.		24a. REC'D BY REGISTRAR MAY 9 '61	24b. REGISTRAR'S SIGNATURE William L. Krass

MEDICAL CERTIFICATION



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

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FOR STATE
HEALTH DEPT.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
5702 05691									
1. PLACE OF DEATH a. COUNTY Howard					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Woodstock					c. LENGTH OF STAY IN 1b Woodstock				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Groomes Lane					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) ROBERT LEE PLATT					4. DATE OF DEATH May 24 1961				
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov 27 1906		9. AGE (In years last birthday) 54 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) pipe fitter					10b. KIND OF BUSINESS OR INDUSTRY D.C.A. Machine			11. BIRTHPLACE (State or foreign country) West Virginia	
13. FATHER'S NAME James R. Platt					14. MOTHER'S MAIDEN NAME Dora Shifflett				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no					17. INFORMANT Mrs Icie Platt Groomes Lane, Woodstock, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Arteriosclerotic cardio vascular disease 11 yrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c)					INTERVAL BETWEEN ONSET AND DEATH 15min				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) none									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE George E. Burgtorf					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) George E. Burgtorf M.D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
					DATE SIGNED 5/24/61				
					Address (Street, city, town, or county)				
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 5/27/61		22c. NAME OF CEMETERY OR CREMATORY Good Shepherd		22d. LOCATION (City, town, or country) (State) Ellicott City, Md.			
23. FUNERAL DIRECTOR F.C.Higinbothom					24a. REC'D BY REGISTRAR DATE MAY 29 '61				
					24b. REGISTRAR'S SIGNATURE Arthur L. Hines				

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FOR STATE
HEALTH DEPT.

TO DEATH CITY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Howard		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b MAYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Howard	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. STREET ADDRESS Woodlawn Woodland Farms		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CHARLES JAMES		First Middle Last CHARLES JAMES RHOADES		4. DATE OF DEATH May 2 1961		5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH March 8, 1961		9. AGE (In years last birthday) 24 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Wilmington, Del.		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Charles James Rhoades		14. MOTHER'S MAIDEN NAME Margaret F. Goodyear		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Charles J. Rhoades, Woodla	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Otitis media 391.2 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)								INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type) W. Bradley King, Jr., M.D.		DATE SIGNED 5/3/61							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-5-61		22c. NAME OF CEMETERY OR CREMATORY Hickory Grove		22d. LOCATION (City, town, or country) St. Georges, Del			
23. FUNERAL DIRECTOR F.C. Higinbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR DATE MAY 5 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Kiser			

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CERTIFICATE OF DEATH

Reg. Dist. No. 05693

5704

1. PLACE OF DEATH o. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DANIELS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DANIELS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>#26 Long Brick Row</u>				d. STREET ADDRESS <u>#26 Long Brick Row</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE U Rohrbach</u>				4. DATE OF DEATH Month Day Year <u>May 16 1961</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/12/1878</u>		9. AGE (In years lost birthday) <u>82</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CUTTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TEXTILE mill</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Otha Rohrbach</u>				14. MOTHER'S MARDEN NAME <u>Cordelia Morris</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-01-9429</u>		INFORMANT <u>Mrs Grace Rohrbach DANIELS, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular occlusion</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Arteriosclerotic Cardiovascular disease</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1 da</u> <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar. 22</u> , 19 <u>59</u> , to <u>May 16</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>May 15</u> , 19 <u>61</u> , and that death occurred at <u>9:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas F. Herbert</u> M.D.		ADDRESS (Street, city or town, state) <u>46 Church Road</u>				DATE SIGNED <u>5/16/61</u>	
PHYSICIAN'S NAME (Type) <u>Thomas F. Herbert, M.D.</u>		<u>Ellicott City, Md</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/19/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LOCUST VALLEY</u>		22d. LOCATION (City, town, or county) (State) <u>Middle town Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F.C. Higginbotham</u>				ADDRESS <u>Ellicott City, Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 18 '61</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE UNIVERSITY OF TEXAS AT AUSTIN

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15/11/57 Maryland

CTH 18-01020-4

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215-01-1777 (Case of) 2008-10-15

241

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1X
The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO HOSPITAL OR ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.
VR A15 (4)
15M 9/60

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MAY 1 1961
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
05694

1. PLACE OF DEATH a. COUNTY <u>HOWARD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>MD</u> b. COUNTY <u>HOWARD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELLICOTT CITY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELLICOTT CITY</u> X	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SCHAEFFER CONV. HOME</u>		d. STREET ADDRESS <u>R.D. #2</u>	
3. NAME OF DECEASED (Type or print) <u>FRANCES B. SMITH</u> First Middle Last		4. DATE OF DEATH <u>MAY 4 1961</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/18/83</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOMESTIC</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PA.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MICHAEL Mc GUIGAN</u>		14. MOTHER'S MAIDEN NAME <u>KUGLER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>MRS. BEATRICE REED</u>	
17. INFORMANT Address <u>MRS. BEATRICE REED</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure.</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>-</u> (e), stating the underlying cause last. DUE TO (c) <u>Cerebral Hemorrhage.</u> INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> 4 weeks.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 25, 1961</u> to <u>May 4, 1961</u> , that (I) (we) last saw the deceased alive on <u>April 25, 1961</u> , and that death occurred at <u>5P</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>William F. Gassaway</u> M.D.		22b. DATE SIGNED <u>5/4/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>WILLIAM F. GASSAWAY</u>		22d. ADDRESS <u>ELLICOTT CITY, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>5/5/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>LOUDON PARK</u>		23d. LOCATION (City, town or county) (State) <u>BALTO, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>M. M. STAFF + Son</u>		25a. REC'D BY REGISTRAR <u>28</u> DATE <u>MAY 8 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>			

10320

10320

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MD MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5706

Items 8 & 9 fill in 6-286 5/8/61 iwk

05695

1. PLACE OF DEATH a. COUNTY Howard b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural-- Woodbine c. LENGTH OF STAY IN 1b 1 1/2 Yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) R. D. # 1				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural-- Woodbine d. STREET ADDRESS R. D. # 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) JESSE		First CALVIN		Middle WALKER		Last May		4. DATE OF DEATH Month 1 Day 19 Year 61							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 23, 1877		9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 1 Days 19		IF UNDER 24 HRS. Hours 61 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer, Retired				10b. KIND OF BUSINESS OR INDUSTRY Farming				11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Harry Clinton Walker				14. MOTHER'S MAIDEN NAME Angenette Kaiser											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) -----				16. SOCIAL SECURITY NO. 219-20-9074				17. INFORMANT Mr. Earl E. Walker, Same as # 2				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis, arteriosclerosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Generalized. (c) Generalized. DUE TO (e), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH Jan 61 to 1 May 61			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
2Dc. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year 19		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		2Da. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		2Df. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from Jan 1 May 1961 , to 1 May 1961 , that (I) (we) last saw the deceased alive on 1 May 1961 , and that death occurred 6:45 A.M. from the causes and on the date stated above.															
22a. SIGNATURE Howard E. Hall				M.D. Howard E. Hall, M. D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 1 May 61			
22c. PHYSICIAN'S NAME (Type) Howard E. Hall, M. D.				22d. ADDRESS Sykesville, Maryland											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-4-1961		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery				23d. LOCATION (City, town or county) Frederick, Maryland				(State)			
24. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, Winfield				ADDRESS				25a. REC'D BY REGISTRAR MAY 3 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hirsch					

VR A15 (4)
ISM 9/60

2506

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Howard

Howard

Howard

Howard -- Woodbine

Howard -- Woodbine

S. D. 41

S. D. 41

James

James

May

Male White

Male White

Turner, Rector

Turner, Rector

Harry Clinton Walker

Harry Clinton Walker

(I)

210-80-0074 Mr. Earl H. Walker, Same as 32

Spokane, Idaho

Spokane, Idaho

C. H. Walker, Spokane

Spokane, Idaho

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

5707

05696

1. PLACE OF DEATH a. COUNTY <i>Howard</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MD</i> b. COUNTY <i>Howard</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Laurel - Rural</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Laurel - Rural</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Grant Ave</i>				d. STREET ADDRESS <i>Grant Ave</i>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Nora Edith Whiting</i>				4. DATE OF DEATH Month Day Year <i>May 9 1961</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Dec 22, 1884</i>		9. AGE (In years last birthday) <i>76</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Larry</i>				14. MOTHER'S MAIDEN NAME <i>Sara Margaret</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <i>Mrs Dunnington, Laurel Md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Myocarditis</i> <i>422.2</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>April 5, 1960</i> to <i>May 9, 1961</i> , that (I) (we) last saw the deceased alive on <i>May 9, 1961</i> , and that death occurred at <i>11 A.M.</i> from the causes and on the date stated above.							
22a. SIGNATURE <i>Robert S. McCeney M.D.</i>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>ROBERT S. MCCENEY M.D.</i> <i>402 MAIN ST.</i>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>May 11, 1961</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Glennville Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Glennville, W. Virginia</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>De Witt Donaldson, Laurel Md</i>				25a. RECEIVED BY REGISTRAR <i>May 15 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1930

CERTIFICATE OF DEATH

2703

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Blank certificate form with faint lines and text, including "CERTIFICATE OF DEATH" and "1930".

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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5708

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05697

1. PLACE OF DEATH a. COUNTY <i>Howard</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Howard</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Crooksville</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Crooksville</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>Ebster</i> First <i>May</i> Middle <i>Wilson</i> Last				4. DATE OF DEATH <i>May 28</i> 19 <i>61</i> Month Day Year			
5. SEX <i>M.</i>		6. COLOR OR RACE <i>Col.</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Jan. 1, 1889</i>	
9. AGE (In years last birthday) <i>72</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>							
13. FATHER'S NAME <i>John Hall</i>				14. MOTHER'S MAIDEN NAME <i>Emma Smith</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <i>Donald Wilson - Crooksville, md.</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Edema</i> <i>443 X</i> DUE TO <i>Hypertensive Interstitial Heart Disease with Congestive Failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>② mild diabetes</i> DUE TO <i>Hypertension</i> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <i>6 wks</i> <i>3 yrs +</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <i>28 Feb</i> 19 <i>59</i> to <i>28 May</i> 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>13 May</i> 19 <i>61</i> , and that death occurred at <i>4</i> M, from the causes and on the date stated above.							
22a. SIGNATURE <i>C. R. Davidson</i>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <i>Charles R. Davidson</i>				22d. ADDRESS <i>305 A Winters Lane</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF <i>5-30-61</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Hopkins Chapel</i>	
23d. LOCATION (City, town, or county) (State) <i>Highland, Howard Co., Md.</i>							
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Haight</i> ADDRESS <i>Crooksville, Md.</i>				25a. REC'D BY REGISTRAR DATE <i>MAY 31 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>	

707

CERTIFICATE OF DEATH

207

(M)

I, the undersigned, being a duly qualified Medical Officer of Health for the District of Columbia, do hereby certify that on the 12th day of August 1912, at the City of Washington, District of Columbia, died a person whose name, age, sex, race, date and place of birth, and date and place of death, are as follows:

Signature

12-1912

Witness my hand and the seal of the District of Columbia at the City of Washington, this 12th day of August 1912.